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patients subjected to PMs implantation, initial or replacement, in our center compared with others studies. In the case of ICD implantations, initials or replacements, there weren't any adverse event. The additional hospitalization days and cost attributed to these adverse events depends on the nature of adverse event.

PMD2
RELATIONSHIP BETWEEN ECHOCARDIOGRAPHIC MARKERS AND INDUCIBILITY OF VENTRICULAR ARRHYTHMIAS IN ISCHAEMIC CARDIOMYOPATHY PATIENTS
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OBJECTIVES: Research on prognostic factors of ventricular arrhythmias inducibility in patients with severe reduced LV systolic function being ICD candidates for primary prevention of sudden cardiac death has given limited results so far. Aim of our study was to examine the relationship of specific echocardiographic markers, beyond LV ejection fraction, particularly left ventricular hypertrophy and left ventricular end-diastolic diameter, with ventricular arrhythmias inducibility during electrophysiological study in patients with ischemic cardiomyopathy. **METHODS:** Data were acquired from patients with ischemic cardiomyopathy and severe reduced LV systolic function who underwent electrophysiological in the context of primary prevention of sudden cardiac death. Electrophysiological study protocol included programmed electrical stimulation from right ventricular apex. **RESULTS:** Of 119 patients included, ventricular arrhythmias were induced in 76 (63.9%). Prior echocardiographic study revealed 26 (21%) patients with ventricular hypertrophy (defined as interventricular septum and posterior wall diastolic thickness >11mm) and 90 patients (76.3%) with dilated left ventricle (defined as LV end-diastolic diameter >55 mm). 80% of patients with left ventricular hypertrophy had ventricular arrhythmias induced compared to 59% of patients without ventricular hypertrophy ($p<0.05$). However, as regards LV end-diastolic diameter, difference between groups was not statistically significant ($p=0.92$). **CONCLUSIONS:** In populations at high risk for sudden cardiac death, such as ischemic cardiomyopathy patients, ventricular hypertrophy is correlated to ventricular arrhythmias inducibility and possibly is a risk factor for spontaneous malignant arrhythmias.

PMD3
COMPARISON OF QUANTIFERON TB-GOLD (QFT-GIT) TEST VERSUS TUBERCULIN SKIN TEST (TST) FOR LATENT TUBERCULOSIS INFECTION (LTBI) SCREENING AMONG NATIONAL GUARD GENERAL POPULATION IN SAUDI ARABIA
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OBJECTIVES: To compare QFT-GIT to TST in detection of latent TB infection among National Guard general population in Saudi Arabia. **METHODS:** a total of 1369 subjects chosen randomly from the catchment areas of PHC centers of national Guard Health Affairs in Saudi Arabia. inclusion criteria were Saudi national, age 5 years or more, resident of Saudi Arabia and availability during the study. Exclusion criteria included age less than 5 years (to avoid the BCG vaccination effect on the results), present or previous active tuberculosis, those already diagnosed of having LTBI &/ or on anti TB prophylaxis & all immunocompromised conditions. Blood was drawn and processed using QFT-GIT followed by immediate administration of TST solution on subjects forearm. Data were collected and analyzed using SPSS software. Results were compared using the chi-square test & kappa coefficient was calculated. **RESULTS:** both tests had a significant overall agreement of 88.8% ($k=0.332$; $p<0.001$). Negative concordance represented 85.2% and positive concordance represented 3.6% . Positive QFT-GIT but negative TST was 5.5% of the results while positive TST but negative QFT-GIT was 5.7% of the results. Concordance was associated significantly with younger ages and female gender. Positive results in both tests were significantly associated with older ages and male gender only in 15-44 years age group. **CONCLUSIONS:** The overall agreement of TST & QFT-GIT among Saudi National Guard general population was 88.8% for detection of LTBI. In absence of a gold standard, QFT-GIT showed acceptable results compared to TST for detecting LTBI in intermediate TB burden country with at birth BCG highly vaccinated population.

PMD4
UTERINE FIBROID TREATMENT PATTERNS IN THE THREE YEARS FOLLOWING DIAGNOSIS
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OBJECTIVES: To describe treatment patterns and diagnostic pathways for women with uterine fibroids up to three years following a new diagnosis. **METHODS:** Patients with a new diagnosis of uterine fibroids (ICD-9 code: 218.9) were identified in the Truven Health MarketScan Research Databases from 2004-2013. The use of specific diagnostic and treatment procedures and medications were described in the 12 months prior to (pre-index) and in the 12, 24 and 36 months following (post-index) the diagnosis (index event). Patients were required to have continuous enrollment throughout the pre- and post-index periods. **RESULTS:** A total of 359,672 patients met the selection criteria with mean age 46.1 years (SD=9.3) at first diagnosis. Of those, subsets of 244,827 (68.1%) patients and 164,645 (45.8%) patients had 24 and 36 months of post-index follow-up, respectively. Hysterectomy was the most common surgical intervention, increasing from 29.3% in the first 12 months to 35.5% in the first 36 months; average time to hysterectomy was 49.7 days. Other surgical interventions used within the first 12 months of follow-up included: endometrial ablation (5%), curettage (3.6%), and either hysteroscopic myomectomy, laparascopic myomectomy, abdominal myometcomy, or uterine emobolization (<2% each). 13.1% of women used hormonal birth control with higher rates among younger women. IUDs or Gnrh agonists were used by approximately 1% of women. Transvaginal ultrasound was the most common imaging procedure both 12 months pre- and 36 months post-index (31.0%, 54.6%, respectively), followed by abdominal/pelvic ultrasound (27.3%, 49.6%, respectively). **CONCLUSIONS:** Approximately one-third of women with newly diagnosed uterine fibroids underwent hysterectomy within the first year of initial diagnosis. Minimally invasive procedures such as hysteroscopic myomectomy were infrequently utilized, despite published evidence showing considerably lower costs and complication rates over hysterectomy.

PMD5
COMPARATIVE EFFECTIVENESS OF FIBRIN SEALANTS IN CARDIAC SURGERY
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OBJECTIVES: While effectiveness of fibrin sealants for controlling bleeding in cardiac surgery has been demonstrated, there is a paucity of research on other clinical outcomes of fibrin sealants. In this retrospective observational study we analyzed the clinical outcomes of two different fibrin sealants in a population of patients undergoing cardiac surgical procedures. **METHODS:** Data from patients undergoing coronary artery bypass grafting (CABG), valve and valvular procedures with CABG during the years 2008 - 2012 were extracted from Premier's Hospital Database. The Premier Hospital Database is a comprehensive database containing data from over 6 million US hospital discharges annually. Only surgeries in which a fibrin sealant was utilized were included; all other hemostatic agents were excluded from the study. The following clinical outcomes were assessed: major and minor complications, transfusions, surgical revisions for bleeding, operative mortality (hospitalization), OR time and hospital and ICU length of stay (LOS). Logistic regression analyses were performed on categorical outcome variables and GLM regression analyses were performed on continuous outcome variables. Study covariates included: age, primary procedure, Charlson Co-morbidity Index (CCI) score, heparin use, protamine use, admission type, gender, race, teaching hospital, bed size and region. **RESULTS:** A total of 2,560 inpatient cardiac procedures using fibrin sealant with synthetic aprotinin (FS-apr) were compared to 1,019 procedures using fibrin sealant without aprotinin (FS). Results suggested that FS-apr was associated with significantly lower rates of minor complications (21.1% vs. 27.1%, $p = 0.002$), Day 1 Transfusions (28.6% vs. 36.8%, $p = 0.015$) and ICU LOS (4.7 days vs 7.1 days, $p < 0.0001$) as compared to FS. No significant differences were found between FS-apr and FS on the other clinical outcomes. **CONCLUSIONS:** FS-apr was associated with signficantly lower rates of Day 1 Transfusions, avoidable minor complications and lower average ICU LOS as compared to FS.

PMD6
ALLOGENEIC PERIPHERAL BLOOD VERSUS BONE MARROW HEMATOPOIETIC CELL TRANSPLANTATION FROM UNRELATED DONORS: A META-ANALYSIS
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OBJECTIVES: Peripheral Blood Transplant (PBT) accounted for three-quarters of the Hematopoietic Cell Transplant (HCT) from unrelated donors in the past decade, which indicates it has largely replaced Bone Marrow Transplant (BMT) as the preferred graft source. This shift occurred due to evidence suggesting faster neutrophil and platelet engraftment with the former. However, clinical evidence favoring PBT for other outcomes is inconclusive. Although meta-analyses have compared outcomes for PBT and BMT from related donors, no such analysis has been conducted for unrelated donor procedures. Our objective is to conduct a meta-analysis comparing the outcomes in patients undergoing allogeneic unrelated donor HCT comparing PBTvs.BMT. **METHODS:** We conducted a systematic literature search(PUBMED,CANCERLIT and Cochrane databases) identifying randomized trials and retrospective studies comparing outcomes of allogeneic unrelated donor PBTvs.BMT. We extracted longitudinal transplant outcomes, including acute graft-versus-host disease(GVHD) grade II to IV(aGVHD), chronic GVHD(cGVHD), overall-survival(OS), transplant-related mortality(TRM), disease-free survival(DFS) and relapse from published Kaplan-Meier curves. We used the inverse variance method(Cochrane RevMan5.3.5) to estimate pooled hazard ratios(HRs) and 95% confidence-intervals(CI). HR value<1.00 for an outcome signified PBT as the favorable option compared to BMT. **RESULTS:** One randomized trial and five retrospective studies were included in the analysis. PBT was significantly less favorable than BMT on aGVHD [HR(1.30),CI(1.15 to 1.47)] and cGVHD [HR(1.32), CI(1.16 to 1.49)]. We did not find statistically significant differences in other outcomes:OS [HR(1.02),CI(0.86 to 1.21)], DFS [HR(1.00),CI(0.91 to 1.10)], Relapse [HR(1.02,CI (0.78 to 1.34)] and TRM [HR(0.98),CI(0.77 to 1.24)]. **CONCLUSIONS:** Although PBT is the predominant mode of allogeneic HCT, our meta-analysis found no outcomes for which PBT is favorable compared to BMT. The only statistically significant comparisons indicated increased hazard of acute and chronic GVHD with PBT. While PBT may offer other clinical advantages over BMT that merit weight in clinical decision-making, its failure to demonstrate significant improvements in overall survival, disease-free survival and transplant-related mortality and increased risk of GVHD calls current clinical practice into question.

PMD7
TIME-DEPENDENCE OF FIRST APPROPRIATE THERAPY IN PRIMARY PREVENTION IMPLANTABLE CARDIOVERTER DEFIBRILLATOR PATIENTS: IS DEVICE REPLACEMENT NECESSARY IN PATIENTS WITHOUT PRIOR ICD INTERVENTIONS?
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